DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 6

2. STATE: VIRGINIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 431

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ -0-
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Preprint page 90
Attachment 7.5, ppl-4
NURSING HOME PAYMENT SYSTEM
PAGES 38-39

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~N/A~~ SUPPLEMENT 1 TO ATTACHMENT 4.19-A
NURSING HOME PAYMENT SYSTEM
PAGES 38-42 (INCORPORATED IN 00-08)

10. SUBJECT OF AMENDMENT:
Provider Appeals

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health & Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis Smith

14. TITLE:
Director

15. DATE SUBMITTED:
8/28/2000

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Attn: Reg. Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/1/00

18. DATE APPROVED:
DECEMBER 12, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/00

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V. Campbell

21. TYPED NAME:
CLAUDETTE V. CAMPBELL

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

State of Virginia

PROVIDER REIMBURSEMENT APPEALS (12 VAC 30-20-500 through 30-20-599)

PART I. DEFINITIONS AND GENERAL PROVISIONS

12 VAC 30-20-500. Definitions.

The following words, when used in these regulations, shall have the following meanings:

"Day" means a calendar day unless otherwise stated.

"DMAS" means the Virginia Department of Medical Assistance Services or its agents or contractors.

"Hearing officer" means an individual selected by the Executive Secretary of the Supreme Court of Virginia to conduct the formal appeal in an impartial manner pursuant to Va. Code §§9-6.14:12 and 32.1-325.1 and these regulations.

"Informal appeals agent" means a DMAS employee who conducts the informal appeal in an impartial manner pursuant to Va. Code §§9-6.14:11 and 32.1-325.1 and these regulations.

"Provider" means an individual or entity that has a contract with DMAS to provide covered services and that is not operated by the Commonwealth of Virginia.

12 VAC 30-20-510. Reserved.

12 VAC 30-20-520. General Provisions.

State of Virginia

A. These regulations shall govern all DMAS informal and formal provider reimbursement appeals and shall supersede any other provider reimbursement appeals regulations.

B. A provider may appeal any DMAS reimbursement action that is subject to appeal under Va. Code §9-6.14:1 *et seq.* (the Virginia Administrative Process Act), including DMAS' interpretation and application of payment methodologies. A provider may not appeal the actual payment methodologies.

C. DMAS shall mail all items to the last known address of the provider. It is presumed that DMAS mails items on the date noted on the item. It is presumed that providers receive items mailed to their last known address within 3 days after DMAS mails the item.

D. Whenever DMAS or a provider is required to file a document, the document shall be considered filed when it is date stamped by the DMAS Appeals Division in Richmond, Virginia.

E. Whenever the last day specified for the filing of any document or the performance of any other act falls on a day on which DMAS is officially closed, the time period shall be extended to the next day on which DMAS is officially open.

F. Conferences and hearings shall be conducted at DMAS' main office in Richmond, Virginia or at such other place as agreed to by the parties.

G. Whenever DMAS or a provider is required to attend a conference or hearing, failure by one of the parties to attend the conference or hearing shall result in dismissal of the appeal in favor of the other party.

H. DMAS shall reimburse a provider for reasonable and necessary attorneys' fees and costs associated with an informal or formal administrative appeal if the provider substantially prevails on the merits of the appeal and DMAS' position is not substantially justified, unless special circumstances would make an award unjust.

12 VAC 30-20-530. Reserved.

PART II. INFORMAL APPEALS

12 VAC 30-20-540. Informal appeals.

A. Providers appealing a DMAS reimbursement decision shall file a written notice of informal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the decision. Providers appealing adjustments to a cost report shall file a written notice of informal appeal with the DMAS Appeals Division within 90 days of the provider's receipt of the notice of program reimbursement. The notice of informal appeal shall identify the issues being appealed. Failure to file a written notice of informal appeal within 30 days of receipt of the decision or within 90 days of receipt of the notice of program reimbursement shall result in dismissal of the appeal.

B. DMAS shall file a written case summary with the DMAS Appeals Division within 30 days of the filing of the provider's notice of informal appeal. DMAS shall mail a complete copy of the case summary to the provider on the same day that the case summary is filed with the DMAS Appeals Division. The case summary shall address each adjustment, patient, service date, or other matter disputed and shall state DMAS' position for each adjustment, patient, service date, or other matter disputed. The case summary shall contain the factual basis for each adjustment, patient, service date, or other matter disputed and any other

information, authority, or documentation DMAS relied upon in taking its action or making its decision. Failure to file a written case summary with the Appeals Division in the detail specified within 30 days of the filing of the provider's notice of informal appeal shall result in dismissal in favor of the provider on those issues not addressed in the detail specified.

C. The informal appeals agent shall conduct the conference within 90 days from the filing of the notice of informal appeal. If DMAS and the provider and the informal appeals agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the informal appeals agent shall specify the time within which the provider may file written submissions, not to exceed 90 days from the filing of the notice of informal appeal. Only written submissions filed within the time specified by the informal appeals agent shall be considered.

D. The conference may be recorded for the convenience of the informal appeals agent. Since the conference is not an adversarial or evidentiary proceeding, recordings shall not be made part of the administrative record and shall not be made available to anyone other than the informal appeals agent.

E. Upon completion of the conference, the informal appeals agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 days. Only documentation or information filed within the time specified by the informal appeals agent shall be considered.

F. The informal appeal decision shall be issued within 180 days of receipt of the notice of informal appeal.

12 VAC 30-20-550. Reserved.

State of Virginia

PART III. FORMAL APPEALS

12 VAC 30-20-560. Formal appeals.

A. Any provider appealing a DMAS informal appeal reimbursement decision shall file a written notice of formal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the informal appeal decision. The notice of formal appeal shall identify the issues being appealed. Failure to file a written notice of formal appeal within 30 days of receipt of the informal appeal decision shall result in dismissal of the appeal.

B. The hearing officer shall conduct the appeal and submit a recommended decision to the DMAS Director with a copy to the provider within 120 days of receipt of the formal appeal request. If the hearing officer does not submit a recommended decision within 120 days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

C. In order to conduct the appeal and submit a recommended decision within 120 days, the following are suggested guidelines for hearing officers to use. DMAS and the provider should exchange and file with the hearing officer all documentary evidence on which DMAS or the provider relies within 21 days of the filing of the notice of formal appeal. Only documents filed within 21 days of the filing of the notice of formal appeal should be considered. DMAS and the provider should file any objections to the admissibility of documentary evidence within 7 days of the filing of the documentary evidence. Only objections filed within 7 days of the filing of the documentary evidence should be considered. The hearing officer should rule on any objections within 7 days of the filing of the objections. The hearing officer should conduct the hearing within 45 days

from the filing of the notice of formal appeal. Upon completion of the hearing, DMAS and the provider should have 30 days to exchange and file with the hearing officer an opening brief. Only opening briefs filed within 30 days after the hearing should be considered. DMAS and the provider should have 10 days to exchange and file with the hearing officer a reply brief after the opening brief has been filed. Only reply briefs filed within 10 days after the opening brief has been filed should be considered.

D. Hearings shall be transcribed by a court reporter retained by DMAS.

E. Upon receipt of the hearing officer's recommended decision, the DMAS Director shall notify DMAS and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed within 30 days of receipt of the DMAS Director's letter. Only exceptions filed within 30 days of receipt of the DMAS Director's letter shall be considered. The DMAS Director shall issue the final agency case decision within 60 days of receipt of the hearing officer's recommended decision.

12 VAC 30-20-561 through 12 VAC 30-20-599. Reserved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

C. Extensions of the time frames shall be granted to the Department for good cause shown.

D. Disputes relating to the timeliness established in §2.35 and §2.37, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

PART III.

APPEALS.

§3.1. Repealed.

§3.2. Repealed.

§3.3. Repealed.

§3.4. Repealed.

§3.5. Repealed.

§3.6. Dispute resolution for state-operated NFs.

A. Definitions.

1. DMAS means the Department of Medical Assistance Services.

2. Division Director means the Director of a division of DMAS.

3. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

1. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This shall be the sole procedure available to state-operated providers.

2. The appropriate DMAS Division must receive the reconsideration request within 30 business days after the date of a DMAS Notice of

Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review. The state-operated provider shall submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations.

D. Division Director action. The Division Director shall consider any recommendation of his designee and shall render a decision.

E. DMAS Director review. A state-operated provider may, within 30 business days after the date of the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 business days after the date of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

§3.7. Repealed.

PART IV.

INDIVIDUAL EXPENSE LIMITATION.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in Appendix III.

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